appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by HCFA to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

Subpart Q—Beneficiary Appeals

§ 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a hearing and to judicial review for any individual dissatisfied with a determination regarding his or her Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with HCFA to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them. Section 1876(c)(5) provides that—

(i) An HMO or CMP must establish grievance and appeals procedures; and

(ii) Medicare enrollees dissatisfied because they do not receive health care services to which they believe they are entitled, at no greater cost than they believe they are required to pay, have the following appeal rights:

(A) The right to an ALJ hearing if the amount in controversy is $100 or more.

(B) The right to judicial review of the hearing decision if the amount in controversy is $1000 or more.

(iii) The Medicare enrollee and the HMO or CMP are parties to the hearing and to the judicial review.

(b) *Scope.* This subpart sets forth—

(1) The appeals procedures, as required by section 1876(c)(5)(B) of the Act for Medicare enrollees who are dissatisfied with an ''organization determination'' as defined in § 417.606;

(2) The applicability of grievance procedures established by the HMO or CMP under section 1876(c)(5)(A) of the Act and § 417.604(a) for complaints that do not involve an organization determination;

(3) The responsibility of the HMO or CMP—

(i) To develop and maintain procedures; and

(ii) To ensure that all Medicare enrollees have a complete written explanation of their grievance and appeal rights, of the steps to follow, and of the time limits for each step of the procedures; and

(4) The special rules that apply when a beneficiary requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

[60 FR 46233, Sept. 6, 1995]

§ 417.602 Definitions.

As used in this subpart, unless the context indicates otherwise—

ALJ stands for administrative law judge.

RRB stands for Railroad Retirement Board.

[50 FR 1346, Jan. 10, 1985, and amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

§ 417.604 General provisions.

(a) *Responsibilities of the HMO or CMP.* (1) The HMO or CMP must establish and maintain—

(i) Appeals procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(ii) Grievance procedures for dealing with issues that do not involve organization determinations.

(2) The HMO or CMP must ensure that all enrollees receive written information about the grievance and appeals procedures that are available to them.

(b) *Limits on applicability of this subpart.* (1) If an enrollee requests immediate PRO review (as provided in § 417.605) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to subsequent review of that issue under this subpart; and

(ii) The PRO review decision is subject to the appeals procedures set forth in part 473 of this chapter.

(2) Any determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further liability for payment are not subject to appeal.